GOVERNOR'S TASK FORCE TO IMPROVE ACCESS TO ORAL HEALTH

Since the Surgeon General's report was released in 2000, states have been experimenting with reforms to oral health delivery systems. These reforms include increasing dentist reimbursement rates, simplifying administrative tasks, educating Medicaid clients about the dental system and the importance of preventive care, expanding the scope of practice for dental hygienists, and creating loan forgiveness programs for dentists willing to take Medicaid patients or work in shortage areas.

There are many challenges involved with creating access to dental care but since dental disease is preventable, after the initial investment of treating existing disease, it is relatively inexpensive to maintain healthy teeth through education, appropriate use of fluorides, and regular oral hygiene. True prevention requires an understanding of the importance of oral health as well as access to dental health professionals.

In spite of the obstacles, the members of the Task Force to Improve Access to Oral Health worked diligently for eight months to identify innovative, viable, dynamic solutions to the access problem.

The following is a summary of their discussion and final recommendations on topics relating to improving access to oral health.

Dental Professionals Workforce Recruitment, Training and Loan Assistance

Wisconsin operates a Health Professions Loan Assistance Program through the Department of Commerce. The program provides for repayment of medical and school loans incurred by physicians, nurse practitioners, physician assistants, certified nurse midwives, dentists, and dental hygienists who agree to practice primary care in designated dental health professional shortage areas in Wisconsin.

Designed to provide incentives for health care providers to locate their practice in Wisconsin's rural and urban health professional shortage areas, the program provides dentists up to $50,000 and dental hygienists up to $25,000 in loan repayment over a three-year period.

During each of the three years of the award, dentists and dental hygienists must provide dental services in a federally designated shortage area to a certain minimum number of recipients of Medicaid or BadgerCare.

For awards partially funded by federal matching dollars, additional provisions apply, including: recipients must work in public or non-profit sites and recipients must accept Medicaid assignment and must utilize a sliding fee scale for those persons with incomes up to 200 percent of the federal poverty level.

The Task Force discussion focused on removing the requirement of practicing in a designated shortage area and tying loan assistance *only* to serving Medicaid and uninsured populations. Members pointed out that covering children in need was the priority, not location of the dentist or dental hygienist.

The Task Force heard a presentation from the Wisconsin Office of Rural Health (WORH). The WORH was established in 1975, within the University of Wisconsin's Medical School, to address shortages of health services in rural areas. As the WORH evolved, it developed a strong health professional recruitment program and worked with programs at the federal and state levels to bring health care services to underserved areas.

The WORH has recently expanded efforts to recruit oral health professionals to shortage areas. Their past efforts to recruit physicians have been successful.

Members also discussed existing public health education during dental school and the need for education in public health to continue after graduation.

The Task Force Recommends

1. The Task Force recommends continued or increased funding for the state's health care provider loan forgiveness programs and that the eligibility for the loans be linked to serving an unduplicated number Medicaid or BadgerCare recipients not to fall below a certain minimum amount of claims paid* or to serving in a dental health professional shortage area.

   *The program requires a minimum of:
   - 50 recipients served and $8000 in claims paid during the first year of the award.
   - 70 recipients served and $11,000 in claims paid the second year.
   - 90 recipients served and $15,000 in claims paid the third year and continuing years.

2. Direct the Department of Commerce to work with the Rural Health Development Council to develop a dentist recruitment model and tools to be used in recruiting oral health professionals to rural and urban dental health professional shortage areas.

3. The Task Force recommends that the Governor encourage the Wisconsin Dental Association to provide dental education at their annual sessions that would help general dentists become familiar with the care of children from 1 to 3 years of age.

Marquette University School of Dentistry

A Doctor of Dental Surgery (DDS) degree requires four years of dental school after completing an undergraduate program. The state's only dental school is the Marquette University School of Dentistry (Marquette). The dental school was built to accommodate 80 new students per year for a total of 320 students enrolled in the four-year program.

Marquette receives a subsidy (capitation) from the State of Wisconsin to provide a reduced level of tuition for a limited number of Wisconsin residents who attend this school. The capitation amount is currently $8,753 per student with a limit of 160 Wisconsin residents covered per year (40 Wisconsin students per class). The 2003-05 Budget reduced the capitation amount per student from $11,670.

Fifty Wisconsin applicants presently would qualify for admission into the dental school each year according to standards set by the school. Marquette has said that they will accept at least 50 Wisconsin dental applicants each year if the state increases the tuition assistance funding for an additional 10 residents.

History of Higher Educational Aids Board
Capitation Payments for Wisconsin Student Tuition
To Marquette University School of Dentistry

Fiscal Year	Statutory Limit	# of Students
2000-01	$1,167,000	100
2001-02	$1,342,100	100
2002-03	$1,517,100	113
2003-04	$1,269,100	145
2004-05	$1,400,400	160

The Task Force discussion centered on the number of Wisconsin applicants and on their post-graduate decisions to stay in Wisconsin or go elsewhere to practice. Task Force members decided that we have little control over new dentists' choices that are based on non-financial factors but that Wisconsin students were the most likely to stay in the state to practice upon graduation from dental school so this funding is important.

The Task Force recommends:

1. The Task Force recommends that the state increase the annual funding from the Higher Educational Aids Board to support annual capitation payments for 50 Wisconsin students in each future class at the Marquette University School of Dentistry. Funding would begin in the Fall 2006 semester. This is an increase of ten Wisconsin students per class.

2. The Task Force recommends that the state increase the tuition subsidy for Wisconsin residents who attend Marquette University School of Dentistry from $8,753 to $11,670 per year.

Dental Hygienist Workforce

According to the Department of Regulation and Licensing, there are 3,450 active, licensed dentists and 4,190 active, licensed dental hygienists in Wisconsin. According to a 2000 Dental Hygiene Workforce survey from the Dental Hygiene Association of Wisconsin, one out of four dental hygienists do not feel there are enough job opportunities for them in the dental field.

A dental hygienist must graduate from a program accredited by the American Dental Association Commission on Dental Accreditation, pass a written national examination and a practical clinical examination to become eligible for Wisconsin licensure. Dental hygiene is the performance of educational, preventive or therapeutic dental services as defined in the Wisconsin Statutes s. 447.01(3). A dental hygienist may practice dental hygiene or perform remediable procedures as authorized by a dentist who is present in the facility or under a written or oral prescription from a dentist or in limited circumstances where a dentist is not present.

Ten of sixteen technical college districts in the Wisconsin Technical College System offer associate degree programs that prepare students to become dental hygienists. To achieve accreditation, the technical college program must meet certain standards that students will not graduate without training in:

- Providing dental hygiene care for the child, adolescent, adult and geriatric patient.
- Assessing the treatment needs of patients with special needs.

State statutes and administrative rules of the Dentistry Examining Board specify certain activities that a dental hygienist may legally perform while a dentist is present in the facility, practices that a dental hygienist may legally perform whether or not a dentist is present in the dental facility, and prohibited practices for dental hygienists.

The Task Force was presented with information on differing legal opinions on the activities that can be performed by a dental hygienist with and without the prescription or presence of a dentist. The Department of Regulation and Licensing received an opinion from the Attorney General's office stating that Wisconsin statutes "plainly delineate three circumstances where a dental hygienist may apply dental sealants or fluoride treatments without either the authorization or the presence of a dentist." (*See Appendix E*)

The discussion focused on venues where access could be improved if dental hygienists were allowed to practice more independently.

The Task Force recommends:

1. The Task Force recommends that Wisconsin State Statutes be amended to align the dental hygienist scope of practice with accreditation standards and to allow dental hygienists to practice independently under that legal scope of practice. Monica Hebl asked to be recorded voting no.

2. The Task Force recommends that the Governor assemble a study group to examine the feasibility of developing an advanced practice dental hygienist education program in Wisconsin. The group could include the Wisconsin Dental Association, the Dental Hygiene Association of Wisconsin, the Wisconsin Dental Hygiene Association, the Wisconsin Technical College System Dental Hygiene programs, the Marquette School of Dentistry, the University of Wisconsin System and other health providers.

3. The Task Force recommends that the Governor propose a state legislative initiative to expand a dentist's ability to delegate dentistry practices and procedures.

Community Water Fluoridation

Currently, approximately 70 percent of Wisconsin's population resides in areas with public water systems. Approximately 90 percent of this population residing on public water systems has optimally fluoridated water. This results in 63 percent of Wisconsin's total population receiving the benefits of appropriate levels of fluoride.

Communities interested in fluoridation of their water supply need to purchase equipment to fluoridate water at each system pump house, may need to construct additional building space to house the equipment, and need to provide funding for operations and maintenance staff. Current funding in Wisconsin for community fluoridation systems is limited to an allocation from the federal prevention block grant. The state provides $3,500 annually from this federal block grant.

The Task Force recommends:

1. The Task Force recommends an increase in state funding available for communities to fluoridate their water supply. The Task Force recommends providing $25,000 in annual, non-lapsing funding.

Medicaid Funding and System Changes

The Task Force members had many long discussions about the effect of Medicaid reimbursement rates on access to oral health and about the effectiveness of the HMO dental systems in four Southeastern Wisconsin counties.

Medicaid Reimbursement Rates

There was general agreement among the membership that reimbursement rates for dental services should be increased.

Several models were developed to show the fiscal effect of increases in the rate. One model would increase the rate by 10 percent each year of the biennium with the goal of rewarding participating dentists to continue their existing service to Medicaid clients. This model acknowledged the reality of the existing Medicaid deficit and improbability of appropriating millions of additional dollars in the existing fiscal environment.

One model would increase the rate to the 75th percentile with the goal of increasing the number of providers who would accept Medicaid clients under a higher reimbursement rate. The Wisconsin Dental Association advocated for funding at the 75th percentile based on their assertion that increasing the rates to that level has been successful in increasing access to dental care in other states and that small incremental increases would not be enough to attract more dentists to the Medicaid program.

Agreement could not be reached by the members on any of the presented models.

The Task Force recommends:

1. The Task Force recommends a $20 million annual increase in state funding to increase the dental reimbursement rate and require that future investments in the dental Medicaid program include pay-for-performance strategies that assure increased access, regardless of the delivery system (i.e. whether services are delivered through fee-for-service or through HMOs).

2. The Task Force recommends the adoption of a tax on soda purchases (like the Two Cents for Tooth Sense plan) with the revenues going to the dental Medicaid program and other funding priorities as recommended by the Governor's Task Force to Improve Access to Oral Health.

HMO Dental Services

The Department of Health and Family Services began an extensive analysis of the performance of Wisconsin's various dental delivery systems in 2003. The Department analyzed a variety of data about dental care provided to HMO enrollees and compared it to Medicaid and BadgerCare fee-for-service clients. The analysis yielded the following conclusions:

- HMO-enrolled children were less likely to receive dental care than children receiving fee-for-service dental benefits in 2003. HMO-enrolled adults, by comparison, were more likely to receive dental care than their fee-for-service counterparts.
- Among clients receiving care, HMO enrollees received approximately the same number of dental services as fee-for-service clients.
- Pricing HMO-reported dental encounters at fee-for-service rates shows that if the services reported by the HMOs were provided in the fee-for-service system, the Department would have paid $2.7 million less than it did for dental services provided by HMOs during SFY 2003.
- Delivery of preventive dental care by HMOs to children who have been enrolled in the same HMO for at least ten months has increased over the last several years, to levels exceeding those of the comparable fee-for-service population.
- HMO enrollees who receive dental services report high satisfaction with the service delivery system, and there is little evidence of unresolved grievances related to inability to access dental care.

Although the HMO delivery system is not yet operating at the level that the Department would desire, this system does show improvement, especially among continuously enrolled clients. In addition, the managed care model provides contractual guarantees that the Department can enforce to ensure that dental care will be provided patients in need of dental care will be provided that care.

Based on this analysis, the Department's Health Care Financing staff made the following recommendations for Medicaid dental administration:

- Emphasize that future investments in the Medicaid dental program should be spent in pay-for-performance strategies that assure increased access, regardless of the delivery system.
- Reform the HMO delivery system, and strengthen contractual guarantees not available in the current fee-for-service delivery system to improve the level of service provided to clients.
- Fully investigate the "carve-out" option, including the development of a request for information on a contract for statewide dental benefits administration.
- Support the efforts of the Governor's Task Force on Access to Oral Health Care.

The Task Force was most concerned 1) about children not having the same access to care that they would have under the fee-for-service model, 2) about the three tier system (HMO, Dental Administrator, and dentists) spending too much on administrative costs before the oral health provider received payment for care provided, and 3) about the complexity of the system which potentially leaves clients uncertain of whom to call when they cannot get an appointment.

Specifically, the members feel that the current complaint system is inadequate in determining if care levels and access requirements (90 days for non-emergency care and 24 hours for emergencies) are being met. While members were supportive of the access guarantees under managed care, the additional cost of these contracts was questioned due to uncertainty about clients' ability to get an appointment as required.

The Task Force recommends:

1. The Task Force recommends that the Department of Health and Family Services develop a request for information on a contract for a statewide dental benefits administrator. This "carve out" option would remove dental claims processing and customer service from both the state's current HMO and fee-for-service systems. The state would contract with a specialized dental benefits administrator for provision of these services and maintenance of a dental provider network. Ideally, the contract would include enforceable benchmarks regarding utilization and access targets, and expanded customer outreach and education requirements.

2. Under the current HMO dental delivery system, the Department of Health and Family Services would develop a complaint form for use by current HMO dental system patients who are unable to access dental care in the contractually required timeframe. The Department would share the form with HMO medical providers in the four-county region and would include information about who to contact when they are unable to access service within 90 days for non-urgent care and within 24 hours for urgent care. The form, once completed by the HMO client, would be sent to DHFS as a formal complaint regarding HMO access to dental care.

HealthCheck

Federal law entitles all children enrolled in Medicaid to coverage of any medically necessary dental services found as a result of a screening under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is the nation's primary source of well child care for low-income youths through age 20. HealthCheck is Wisconsin Medicaid's EPSDT Program.

The Task Force discussed discrepancies in the recommended age for the first EPSDT screening.

The Task Force recommends:

1. The Task Force recommends that the Department of Health and Family Services coordinate the Early and Periodic Screening, Detection, and Treatment (HealthCheck) periodicity schedule with the American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommendations which changes the age of the first screening from age 3 to age 1.

Shared Responsibility

The Task Force also had a presentation on the Children's Hospital of Milwaukee's Clear Path program that works to develop shared respect between dentists and Medicaid recipients. This education and awareness model is one example of programs that are being developed in other areas of the nation that asks families to understand the demands of a dentist's schedule and business at the same time as it makes dentists and their staff aware of the needs of poor and low-income families. Informal outcomes have shown increased access for families needing dental care and decreased no-show rates at appointments.

The Task Force recommends:

1. The Task Force recommends that the Governor explore the expansion of Clear Path with Children's Hospital of Milwaukee and the Greater Milwaukee Dental Association. Clear Path is the hospital's training program for individuals looking for access to dental care. Individuals that attend the training are guaranteed an appointment at the dental clinic within six weeks. The program helps the dentists understand the pressures of the families seeking care and helps the families understand how their actions affect the dentist, the office, and the care of all clients. Monica Hebl asked to be recorded voting no.

2. The Task Force recommends that the Department of Health and Family Services develop patient education materials and programs to encourage responsible use of health care systems for distribution or presentation to Medicaid enrollees. Materials should include education on the importance of keeping and showing up on time for appointments and on proper behavior in waiting rooms.

3. The Task Force recommends funding two pilot grant programs, based loosely on the Washington ABCD Kids Get Care program, across the state. The two-year grants would include annual funding for a case manager, a community educator, and materials and supplies.

   To be eligible for the grants, a project would need to:

   - Show proof of commitment from an adequate number of area dentists who agree to be providers under an enhanced Medicaid dental fee.
   - Include at least one local government entity (required to gain eligibility for federal HCFA funds) willing to provide caseworkers to do outreach.
   - Establish an oversight task force that includes at least one representative from an oral health or children's health advocate organization, local health department, the dental community, and a K-12 education and/or day care provider and/or a pre-school or HeadStart organization. Meetings must occur at least quarterly during the two-year grant process.
   - Identify an organization willing to develop and deliver the program training.

   Pilots would be selected on ability to provide care and prevention to a wide group of children and based on the program's ability to be used as a model for other areas of the state.

Dentists who wish to be licensed in Wisconsin must:

1. Submit an application.
2. Pay a fee.
3. Present evidence satisfactory to the board of having completed the educational requirements in s. 447.04(1) Stats.
4. Present verification of successful completion of a required examination, clinical/laboratory demonstrations, and ethics and jurisprudence training.
5. Complete any other requirement established by the Dentistry Examining Board by rule.

The Task Force discussed creating a pathway for qualified, foreign-trained dentists to gain licensure in Wisconsin. Currently the Dentistry Examining Board has not approved a foreign graduate evaluation program.

The members also discussed Wisconsin's current acceptance of only two of four available regional exams in the United States. The members were supportive of a national exam being available in the near future.

The Task Force recommends:

1. The Task Force recommends that current law be amended to provide that an applicant may pass any one of the four regional exams for Wisconsin licensure. When a national exam is approved, passage of that exam would also allow an applicant to receive licensure in Wisconsin upon completion of required testing and application. David Carroll asked to be recorded voting no.

2. The Task Force recommends that Wisconsin create a special training license available to foreign-trained dentists that would allow practice in an American Dental Education Association approved residency program leading to full licensure. The residency period would last a minimum or two years and could lead to full licensure. There would have to be a supervision requirement with endorsement for full licensure contingent on the supervisor attesting to competency. Licensure would also require passage of national boards, an approved exam, and Wisconsin's ethics and jurisprudence exam. David Carroll and Monica Hebl asked to be recorded voting no.

3. The Task Force recommends that Wisconsin allow licensure of a foreign-trained dentist that completed an American Dental Education Association approved 2-year residency training program in an approved United States accredited school. Also, the dentist must have been licensed by and practiced in another state. Licensure would also require passage of national boards, an approved exam, and Wisconsin's ethics and jurisprudence exam. David Carroll and Monica Hebl asked to be recorded voting no.

Oral Health Safety Net Program Funding

The Task Force discussed other providers in addition to private dentists that could help expand access to dental care for low-income clients in Wisconsin. (*See Appendix H*) These "safety net" clinics provide services to a population that otherwise may not have access to health care.

- Ten of the 15 Federally Qualified Health Centers (FQHCs) have on-site, comprehensive dental programs for low-income individuals. Federally Qualified Health Centers (FQHCs) provide primary and preventive health care services in medically underserved areas. They receive federal dollars to provide primary care to low income clients and receive reimbursement for reasonable costs related to serving Medicaid recipients.
- Seven of the 11 tribal clinics in Wisconsin have comprehensive dental services provided.
- Marquette University School of Dentistry operates several outreach clinics.
- The rural dental health program funds two clinics in Menomonie and Ladysmith in underserved areas of the state. These clinics provide regular and preventive dental care to low income populations.
- As part of its associate degree dental hygiene programs, the Wisconsin Technical College System provides dental hygiene prevention services at 11 of the 16 technical colleges. Three of the technical colleges use their dental facilities both to train dental hygienists and assistants and to provide services to low-income individuals.

The Task Force recommends:

1. The Governor's Task Force recommends that the Governor appoint an ongoing State Oral Health Council made up of a representative from the Legislature, an FQHC representative, a Wisconsin Dental Association designee, an advocate for Medicaid clients, a public health representative, and other dental care advocates. The council should reflect an urban/rural balance.

   Initially, the council would define criteria for a pilot project that would award grants to programs that provide dental care to those unable to access oral health care in the current system (like community clinics, FQHC expansions, hospital clinics, etc.). Grants would be awarded based on the criteria determined. Continued funding would result from meeting outcomes defined in the initial criteria. The Task Force recommends allocation of $200,000 in annual funding for this program.

Regional Oral Health Operations

Oral Health Consultant Contracts: Currently, the Department of Health and Family Services contracts with a Registered Dental Hygienist in all five DHFS regions across the state using a federal Health Resources and Services Administration grant. Regional Oral Health Consultants provide technical assistance for county level pre-school or school-aged surveys, school-based fluoride mouthrinse, dietary fluoride supplement, and school-based or community-based dental sealant program development, maternal and early childhood caries prevention programs, and SmileAbilities, a program for families with children with special health care needs. The current budget provides $9,133 annually per region for these contracts.

Portable Dental Equipment: The cost of a full portable dental operatory (Procart 1- Model #2600, over head light, radiographic unit. patient chair, assistant stool, operator stool, statim, curing lights, and transport cases) is approximately $20,000.

The Task Force discussed the additional training and program development that could be provided if each DHFS regional office was given a full-time oral health staff and the necessary tools.

The Task Force recommends:

1. The Task Force recommends that the state fund five regional oral health consultants at a full-time level.

2. The Task Force recommends funding portable equipment at each Department of Health and Family Services public health region to be used in school based and community oral health programs for restorative and prevention services.

Children with Special Health Care Needs and Targeted Case Management

Some children with severe oral health needs may be eligible for targeted case management services under the Wisconsin Children with Special Health Care Needs (CSHCN) program.

The CSHCN program is funded by the Maternal Child Health Title V Block Grant and serves approximately 274,000 Wisconsin children who have special health care needs as defined under the program. These children are birth to 21 years of age and have a long term, chronic physical, developmental, behavioral or emotional illness or condition. The illness or condition:

- Is severe enough to restrict growth, development or ability to engage in usual activities;
- Has been or is likely to be present or persist for 12 months to lifelong; and
- Is of sufficient complexity to require specialized health care, psychological or educational services of a type or amount beyond that required generally by children.

Examples: cerebral palsy, diabetes, autism, attention-deficit disorder and severe asthma.

Children in this program are eligible for Targeted Case Management, a Medicaid program. Case management services assist recipients and their families to gain access and to coordinate a full array of services, including medical, social, educational, and vocational. These case management services include assessment, case plan development, ongoing monitoring and service coordination.

The Task Force recommends:

1. The Task Force recommends that the Department of Health and Family Services send a notice to local health departments clarifying that children screened in public health programs with severe oral health needs and meeting certain criteria may be designated by the state as a Child with Special Health Care Needs. The child therefore may be eligible for Targeted Case Management services. Direct DHFS to monitor the utilization to determine if further policy development is necessary.

Advocacy, Education, School Based Initiatives, and Local Public Health

The Task Force members recognized their role as advocates for improved access to oral health – a role that did not start with their appointment to the Task Force and will not end with final recommendations being sent to the Governor.

Members also wanted to use their role as a Task Force to promote a greater understanding of oral health as a component of total health.

The Task Force had several discussions about the importance of educating parents and children about the importance of brushing and flossing, about what causes decay, and about the benefits of fluoride. All oral health contacts should include education, as well as care.

The Task Force reviewed information about local government collaborative efforts with area school districts to provide oral health services in schools. These programs exist to deliver screening and sealants using portable equipment. School-based programs eliminate many hurdles to oral health care such as lack of transportation, missed appointments, and language barriers

Members also discussed the benefits of having local dentists involved in community strategic plans on oral health.

The Task Force recommends:

1. The Task Force recommends that the state lobby our federal representatives in support of oral health funding and legislative initiatives.

2. The Task Force recommends that the Department of Health and Family Services take a more proactive role in informing pediatricians and family practitioners about integrating oral health into all health care practices.

3. The Task Force recommends that the Department of Public Instruction (DPI) investigate the possibility of including a question on oral health on the required state exams. DPI should work with the Department of Health and Family Services to implement an oral health curriculum and make it available to all state school districts with the goal of 20 percent participation by 2007.

4. The Task Force recommends that the state provide $100,000 annually to fund 2-year pilot programs that coordinate local public health programs with school district dental programs. Grants would be awarded based on benefits of the initiative. Successful applicants would be required to provide local matching funds for the two years of the program.

5. The Task Force recommends that the Department of Health and Family Services work with local health departments to encourage at least one oral health consolidated contract objective.

6. The Task Force recommends that the Governor encourage the Wisconsin Dental Association, the Wisconsin Public Health Association, and the Wisconsin Association of Local Health Departments Board to help connect government health policy entities with practicing or retired dentists so together they can work on strategies to improve oral health in their communities.